PARAMOUNT
ELITE | COMMERCIAL/HMO

Home Titration - E0601 Attestation Form

Attn: Utilization Management
Phone: 800-891-2520 Fax: 567-661-0846

(Must include DME Prior Authorization Form)

Member Name _____ Paramount ID# _____
Paramount Secondary ID#:_____
(if applicable)

DOB _____ Phone Number _____

REFERRAL SOURCE

Referral Organization_____ Ordering Physician Name _____
Phone Number _____ Date of Clinical Evaluation_____
Face to Face Clinical Evaluation by Treating Practitioner perform prior to the Sleep Study: *Yes* ☐ *No* ☐
Provider Billing Tax ID (TIN):_____

DIAGNOSIS ICD-10: A specific ICD-10 code must be provided

☐ G47.33 Obstructive Sleep Apnea (OSA) (Adult and Child) ☐ Other _____
☐ Secondary condition _____
HCPCS Code Requested: E0601 ☐ E0561 ☐ E0562 ☐

SLEEP STUDY ATTESTATION

Order Date _____ Sleep Study Performed Date_____
Site of Study _____ Phone Number _____
Fax Number _____
AHI/RDI/REI Result: ≥ 15 ☐ or ≥ 5 and < 15 ☐

Symptoms of OSA if ≥ 5 and < 15 (Check All That Apply)
Excessive Day Time Sleepiness ☐ Impaired Cognition ☐
Mood Disorders ☐ Insomnia ☐
Hypertension ☐ Ischemic Heart Disease ☐
History of Stroke ☐

PEDIATRIC ONLY (< 18 years of age)
Weight ≥ 30 kg/66 lbs: Yes ☐ *No* ☐
Adenotonsillectomy: Unsuccessful ☐ *Contraindicated* ☐
Definitive Surgery is indicated but must await complete Dental and Facial Development: Yes ☐ *No* ☐
AHI > 1.5: Yes ☐ *No* ☐

HOME TITRATION CRITERIA

The individual does not have any comorbid conditions that would be expected to degrade the accuracy of Auto Titration as indicated in the Medical Policy: Yes ☐ No ☐
Instructions in the proper use and care of equipment given: Yes ☐ No ☐
Provider Attests Compliance for Continued PAP Use after 90 days: Yes ☐ No ☐ N/A ☐
Follow up Home Titration using APAP is considered medically necessary when all the following criteria are met as indicated in the Medical Policy: Yes ☐ No ☐

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the item(s) prescribed.

Print Provider's or DME Provider Name _____ NPI # _____
Provider's or DME Provider's Signature _____ Date _____

Revised Date: 5/2024